		FOR OHF USE					

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2003
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2003)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0028134

Facility Name: LAKEVIEW LIVING CENTER

Address: 7270 SOUTH SHORE DRIVE (Number) CHICAGO (City) 60649 (Zip Code)

County: CHK

Telephone Number: (773)721-7700 **Fax #** (773)721-9712

IDPA ID Number: 362324108001

Date of Initial License for Current Owners: 05/23/83

Type of Ownership:

[X]	VOLUNTARY,NON-PROFIT	[ ]	PROPRIETARY	[ ]	GOVERNMENTAL
[X]	Charitable Corp.	[ ]	Individual	[ ]	State
[ ]	Trust	[ ]	Partnership	[ ]	County
IRS Exemption Code	501©(3)	[ ]	Corporation	[ ]	Other
		[ ]	"Sub-S" Corp.		
		[ ]	Limited Liability Co.		
		[ ]	Trust		
		[ ]	Other		

In the event there are further questions about this report, please contact:
Name: ROB KEIME **Telephone Number:** (309) 685-0595 EXT 304

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 07/01/02 to 06/30/03 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) _____
(Title) _____

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title) _____
(Firm Name & Address) _____
(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number LAKEVIEW LIVING CENTER # 0028134 Report Period Beginning: 07/01/02 Ending: 06/30/03

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds n/a

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4	145	Intermediate/DD	145	52,925	4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	145	TOTALS	145	52,925	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD	47,018	365		47,383	11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	47,018	365		47,383	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 89.53%

D. How many bed-hold days during this year were paid by Public Aid?
894 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 05/23/83

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 12/01/88 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [X] If YES, enter number of beds certified 0 and days of care provided N/A

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 06/30/03 Fiscal Year: 06/30/03

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number LAKEVIEW LIVING CENTER # 0028134 Report Period Beginning: 07/01/02 Ending: 06/30/03

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	206,520	21,389	9,420	237,329		237,329		237,329			1
2	Food Purchase		157,714		157,714		157,714		157,714			2
3	Housekeeping	87,152	14,685		101,837		101,837		101,837			3
4	Laundry	48,247	21,271	2,517	72,035		72,035		72,035			4
5	Heat and Other Utilities			110,070	110,070		110,070		110,070			5
6	Maintenance	76,760		44,105	120,865		120,865		120,865			6
7	Other (specify):*											7
8	**TOTAL General Services**	418,679	215,059	166,112	799,850		799,850		799,850			8
	B. Health Care and Programs											
9	Medical Director			127	127		127		127			9
10	Nursing and Medical Records	2,235,754	13,195	41,009	2,289,958		2,289,958		2,289,958			10
10a	Therapy			22,105	22,105		22,105		22,105			10a
11	Activities		33,110		33,110		33,110		33,110			11
12	Social Services	20,872		33,665	54,537		54,537		54,537			12
13	Nurse Aide Training	24,626	575		25,201		25,201		25,201			13
14	Program Transportation			11,438	11,438		11,438		11,438			14
15	Other (specify):* ROUTINE DENTAL			9,295	9,295		9,295		9,295			15
16	**TOTAL Health Care and Programs**	2,281,252	46,880	117,639	2,445,771		2,445,771		2,445,771			16
	C. General Administration											
17	Administrative	132,674		269,003	401,677		401,677		401,677			17
18	Directors Fees			25,802	25,802		25,802		25,802			18
19	Professional Services			91,280	91,280		91,280		91,280			19
20	Dues, Fees, Subscriptions & Promotions			14,567	14,567		14,567		14,567			20
21	Clerical & General Office Expenses	104,437	13,918	185,896	304,251		304,251	(3,304)	300,947			21
22	Employee Benefits & Payroll Taxes			637,982	637,982		637,982		637,982			22
23	Inservice Training & Education			709	709		709		709			23
24	Travel and Seminar			13,944	13,944		13,944		13,944			24
25	Other Admin. Staff Transportation			2,640	2,640		2,640		2,640			25
26	Insurance-Prop.Liab.Malpractice			36,058	36,058		36,058		36,058			26
27	Other (specify):*											27
28	**TOTAL General Administration**	237,111	13,918	1,277,881	1,528,910		1,528,910	(3,304)	1,525,606			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,937,042	275,857	1,561,632	4,774,531		4,774,531	(3,304)	4,771,227			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number LAKEVIEW LIVING CENTER #0028134 Report Period Beginning: 07/01/02 Ending: 06/30/03

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			125,245	125,245		125,245		125,245			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			276,667	276,667		276,667	(16,833)	259,834			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			24,189	24,189		24,189		24,189			35
36	Other (specify):*											36
37	**TOTAL Ownership**			426,101	426,101		426,101	(16,833)	409,268			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee				349,456		349,456		349,456			42
43	Other (specify):*				1,476,273		1,476,273	(1,476,273)				43
44	**TOTAL Special Cost Centers**				1,825,729		1,825,729	(1,476,273)	349,456			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,937,042	275,857	1,987,733	7,026,361		7,026,361	(1,496,410)	5,529,951			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number LAKEVIEW LIVING CENTER # 0028134 Report Period Beginning: 07/01/02 Ending: 06/30/03

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs	(1,458,676)	43		3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(91)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(7,678)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest	(212)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(8,760)	43		16
17	Non-Care Related Fees				17
18	Fines and Penalties	(8,441)	43		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(305)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule VENDING, MISC INCOME	(3,304)	21		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (1,487,467)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,487,467)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

LAKEVIEW LIVING CENTER

ID# 0028134

Report Period Beginning: 07/01/02

Ending: 06/30/03

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number LAKEVIEW LIVING CENTER # 0028134 Report Period Beginning: 07/01/02 Ending: 06/30/03

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	0	5	0	0	0	0	0	0	0	0	0	5	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	0	5	0	0	0	0	0	0	0	0	0	5	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	0	5	0	0	0	0	0	0	0	0	0	5	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number LAKEVIEW LIVING CENTER # 0028134 **Report Period Beginning:** 07/01/02 **Ending:** 06/30/03

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(7,890)	(8,743)	(200)	0	0	0	0	0	0	0	0	(16,833)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(7,890)	(8,743)	(200)	0	0	0	0	0	0	0	0	(16,833)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(1,476,273)	0	0	0	0	0	0	0	0	0	0	(1,476,273)	43
44	**TOTAL Special Cost Centers**	(1,476,273)	0	0	0	0	0	0	0	0	0	0	(1,476,273)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(1,484,163)	(8,738)	(200)	0	0	0	0	0	0	0	0	(1,493,101)	45

Facility Name & ID Number LAKEVIEW LIVING CENTER # 0028134 Report Period Beginning: 07/01/02 Ending: 06/30/03

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
RESIDENTIAL CENTERS, INC.	100	SEE ATTACHED RELATED PARTY SCHEDULE				
SEE ATTACHED SCHEDULE 7A						

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	24	TRAVEL	$ 541	RESIDENTIAL CENTERS, INC,	100.00%	$ 541	$	1
2	V	18	BOARD FEES	15,026	RESIDENTIAL CENTERS, INC,	100.00%	15,026		2
3	V	21	OFFICE AND COMPUTER	26,552	RESIDENTIAL CENTERS, INC,	100.00%	26,557	5	3
4	V	22	EMPLOYEE BENEFITS	(1,084)	RESIDENTIAL CENTERS, INC,	100.00%	(1,084)		4
5	V	32	INTEREST	31,335	RESIDENTIAL CENTERS, INC,	100.00%	22,592	(8,743)	5
6	V	19	LEGAL & ACCOUNTING	46,399	RESIDENTIAL CENTERS, INC,	100.00%	46,399		6
7	V	20	LICENSE, DUES & SUBS	15	RESIDENTIAL CENTERS, INC,	100.00%	15		7
8	V	43	NONALLOWABLE	188	RESIDENTIAL CENTERS, INC,	100.00%	188		8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 118,972			$ 110,234	$ * (8,738)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number LAKEVIEW LIVING CENTER # 0028134 Report Period Beginning: 07/01/02 Ending: 06/30/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	21	OFFICE SUPP, TELEPHONE	$ 138,548	CENTER FOR RESIDENTIAL MANAGEMENT, INC.	PARENT CO	$ 138,548	$	15
16	V	22	EMPLOYEE BENEFITS	107,861	CENTER FOR RESIDENTIAL MANAGEMENT, INC.	PARENT CO.	107,861		16
17	V	24	TRAVEL, SEMINAR	9,868	CENTER FOR RESIDENTIAL MANAGEMENT, INC.	PARENT CO.	9,868		17
18	V	9	LICENSE , DUES & SUBS	1,479	CENTER FOR RESIDENTIAL MANAGEMENT, INC.	PARENT CO.	1,479		18
19	V	25	VEHICLE EXPENSE	7	CENTER FOR RESIDENTIAL MANAGEMENT, INC.	PARENT CO.	7		19
20	V	43	NONALLOWABLE	55	CENTER FOR RESIDENTIAL MANAGEMENT, INC.	PARENT CO.	55		20
21	V	18	BOARD FEES	10,776	CENTER FOR RESIDENTIAL MANAGEMENT, INC.	PARENT CO.	10,776		21
22	V	19	LEGAL & ACCOUNTING	40,549	CENTER FOR RESIDENTIAL MANAGEMENT, INC.	PARENT CO.	40,549		22
23	V	35	RENT	7,329	CENTER FOR RESIDENTIAL MANAGEMENT, INC.	PARENT CO.	7,329		23
24	V	32	INTEREST	2,391	CENTER FOR RESIDENTIAL MANAGEMENT, INC.	PARENT CO.	2,191	(200)	24
25	V	30	DEPRECIATION	2,929	CENTER FOR RESIDENTIAL MANAGEMENT, INC.	PARENT CO.	2,929		25
26	V	26	INSURANCE	825	CENTER FOR RESIDENTIAL MANAGEMENT, INC.	PARENT CO.	825		26
27	V	9	UTILITIES/REPAIRS	994	CENTER FOR RESIDENTIAL MANAGEMENT, INC.	PARENT CO.	994		27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 323,611			$ 323,411	$ * (200)	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number LAKEVIEW LIVING CENTER # 0028134 Report Period Beginning: 07/01/02 Ending: 06/30/03

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	RONALD SCHROEDER	PRESIDENT	BOARD MEMBEI	NONE	7,243	3HRS/ MTG		DIR. FEES	$ 4,757	L18, C8	1
2	DARRELL BOEHNE	VICE PRESIDENT	BOARD MEMBEI	NONE	5,810	3HRS/ MTG		DIR. FEES	3,790	L18, C8	2
3	EDWARD CHILDERS	SECRETARY	BOARD MEMBEI	NONE	7,243	3HRS/ MTG		DIR. FEES	4,757	L18, C8	3
4	ROBERT BAUER	TREASURER	BOARD MEMBEI	NONE	1,448	3HRS/ MTG		DIR. FEES	3,352	L18, C8	4
5	CORA FLOTA	BOARD MEMBER	BOARD MEMBEI	NONE	4,108	3HRS/ MTG		DIR. FEES	692	L18, C8	5
6	ORLAND BAUER	BOARD MEMBER	BOARD MEMBEI	NONE	6,269	3HRS/ MTG		DIR. FEES	1,731	L18, C8	6
7	SHAWN JEFFERS	BOARD MEMBER	BOARD MEMBEI	NONE	2,667	3HRS/ MTG		DIR. FEES	2,933	L18, C8	7
8	MERLA MCCLOUD	RECORDER	ADMINISTRATIV	NONE	5,810	3HRS/ MTG		DIR. FEES	3,790	L18, C8	8
9											9
10											10
11											11
12											12
13								TOTAL	$ 25,802		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number LAKEVIEW LIVING CENTER # 0028134 Report Period Beginning: 07/01/02 Ending: 06/30/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: RESIDENTIAL CENTERS, INC.
Street Address: 2020 W. WARMEMORIAL DR. SUITE 103
City / State / Zip Code: PEORIA, IL. 61614
Phone Number: (309)685-0595
Fax Number: (309)685-8463

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	24	TRAVEL	NUMBER OF BEDS	193	4	$ 720	$	145	$ 541	1
2	18	BOARD FEES	NUMBER OF BEDS	193	4	20,000		145	15,026	2
3	21	OFFICE AND COMPUTER	NUMBER OF BEDS	193	4	35,348		145	26,557	3
4	32	INTEREST	NUMBER OF BEDS	193	4	30,071		145	22,592	4
5	19	LEGAL AND ACCOUNTING	NUMBER OF BEDS	193	4	59,841		145	44,958	5
6	20	LICENSE DUES	NUMBER OF BEDS	193	4	20		145	15	6
7	43	NONALLOWABLE	NUMBER OF BEDS	193	4	250		145	188	7
8										8
9										9
10										10
11	22	EMPLOYEE BEN/PAY TAXES	DIRECT METHOD						(1,084)	11
12	19	LEGAL AND ACCOUNTING	DIRECT METHOD						1,441	12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 146,250	$		$ 110,234	25

Facility Name & ID Number LAKEVIEW LIVING CENTER # 0028134 Report Period Beginning: 07/01/02 Ending: 06/30/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: CENTER FOR RESIDENTIAL MANAGEMENT
Street Address: 2020 W. WAR MEMORIAL DR. SUITE 103
City / State / Zip Code: PEORIA, IL. 61614
Phone Number: (309)685-0595
Fax Number: (309)685-8463

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	21	OFF CONST., SUPP & COMPUT	BEDS	331	17	$ 284,669	$ 186,143	145	$ 124,704	1
2	19	PROFESSIONAL FEES	BEDS	331	17	54,060		145	23,682	2
3	24	TRAVEL SEMINAR	BEDS	331	17	13,543		145	5,933	3
4	20	LICENSE, DUES & SUB	BEDS	331	17	393		145	172	4
5	18	BOARD FEES	BEDS	331	17	8,000		145	3,505	5
6	32	INTEREST	BEDS	331	17	5,493		145	2,406	6
7	30	DEPRECIATION	BEDS	331	17	4,795		145	2,101	7
8	26	INSURANCE	BEDS	331	17	1,586		145	695	8
9	25	VEHICLE EXPENSE	BEDS	331	17	16		145	7	9
10	43	NONALLOWABLE	BEDS	331	17	125		145	55	10
11	35	OFFICE EQUIP LEASE	BEDS	331	17	116		145	51	11
12	22	EMPLOYEE BENEFITS	BEDS	331	17	7,010		145	3,071	12
13	35	RENT	BEDS	331	17	16,614		145	7,278	13
14	6	UTILITIES AND REPAIRS	BEDS	331	17	1,598		145	700	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 398,018	$ 186,143		$ 174,360	25

Facility Name & ID Number LAKEVIEW LIVING CENTER # 0028134 Report Period Beginning: 07/01/02 Ending: 06/30/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: CENTER FOR RESIDENTIAL MANAGEMENT
Street Address: 2020 W. WAR MEMORIAL DR. SUITE 103
City / State / Zip Code: PEORIA, IL. 61614
Phone Number: (309)685-0595
Fax Number: (309)685-8463

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	21	OFF CONST., SUPP & COMPUT	BEDS	335	18	$ 28,385	$	145	$ 12,286	1
2	19	PROFESSIONAL FEES	BEDS	335	18	38,969		145	16,867	2
3	24	TRAVEL SEMINAR	BEDS	335	18	5,082		145	2,200	3
4	20	LICENSE, DUES & SUB	BEDS	335	18	675		145	292	4
5	18	BOARD FEES	BEDS	335	18	16,800		145	7,271	5
6	32	INTEREST	BEDS	335	18	(36)		145	(16)	6
7	30	DEPRECIATION	BEDS	335	18	1,915		145	828	7
8	26	INSURANCE	BEDS	335	18	302		145	130	8
9										9
10	32	INTEREST	DIRECT METHOD						(199)	10
11	22	EMPLOYEE BENEFITS	DIRECT METHOD						104,790	11
12	21	OFFICE SUPP/TELEPHONE	DIRECT METHOD						1,558	12
13	20	LICENSE, DUES & SUB	DIRECT METHOD						1,015	13
14	24	TRAVEL SEMINAR	DIRECT METHOD						1,735	14
15	6	MAINTENANCE	DIRECT METHOD						294	15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 92,092	$		$ 149,051	25

Facility Name & ID Number LAKEVIEW LIVING CENTER # 0028134 Report Period Beginning: 07/01/02 Ending: 06/30/03

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	IL HEALTH FAC AUTH. BONDS		X	ACQUISITION OF FACILITI	ANNUAL PMT	12/01/92	$ 6,160,000	$ 2,613,000	08/15/16	0.0850	$ 230,691	1
2	PREMIER CAPITAL GROUP, INC.		X	LAUNDRY EQUIPMENT	$175.00	10/05/99	6,942	2,338	10/05/04	0.1759	561	2
3	NCS HEALTHCARE, INC.		X	SOFTWARE/HARDWARE	$338.00	10/01/98	14,307	2,180	09/30/03	0.1429		3
4	EFFINGHAM STATE BANK		X	PURCHASE OF VEHICLES	$1,083.74	06/24/02	23,986	11,458	05/30/04	0.0818	1,404	4
5	EFFINGHAM STATE BANK		X	PURCHASE OF VEHICLES	$1,086.42	06/18/03	24,502	24,502	06/18/05	0.0630		5
	Working Capital											
6				ALLOCATED FROM PARENT CO.							34,856	6
7				OFFSET INTERST INCOME/ NONALLOWABLE INT.							(7,890)	7
8				MISCELLANEOUS INTEREST							212	8
9	TOTAL Facility Related				$2,683.16		$ 6,229,737	$ 2,653,478			$ 259,834	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 6,229,737	$ 2,653,478			$ 259,834	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ N/A Line #

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number LAKEVIEW LIVING CENTER # 0028134 Report Period Beginning: 07/01/02 Ending: 06/30/03

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2002 report. *Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$		1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$		2
3. Under or (over) accrual (line 2 minus line 1).	$		3
4. Real Estate Tax accrual used for 2003 report. (Detail and explain your calculation of this accrual on the lines below.)	$		4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$		7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1998	N/A	8
	1999		9
	2000		10
	2001		11
	2002		12

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2002	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2002 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME LAKEVIEW LIVING CENTER COUNTY CIIK

FACILITY IDPH LICENSE NUMBER 0028134

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2002 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2002.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	N/A		$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill which is normally paid during 2003.

Facility Name & ID Number LAKEVIEW LIVING CENTER # 0028134 Report Period Beginning: 07/01/02 Ending: 06/30/03

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 36,760 B. General Construction Type: Exterior BRICK Frame WOOD Number of Stories 6

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

NONE

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: N/A
2. Number of Years Over Which it is Being Amortized: N/A
3. Current Period Amortization: N/A
4. Dates Incurred: N/A

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	RESIDENT CARE	26,080	1988	$ 41,516	1
2					2
3	TOTALS	26,080		$ 41,516	3

Facility Name & ID Number LAKEVIEW LIVING CENTER # 0028134 Report Period Beginning: 07/01/02 Ending: 06/30/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	145		1988	1910	$ 1,585,984	$ 45,314	35	$ 45,314	$	$ 660,724	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	BUILDING IMPROVEMENT			1983	5,047		10			5,047	9
10	BUILDING IMPROVEMENT			1984	42,110		15			42,110	10
11	BUILDING IMPROVEMENT			1985	102,043		10			102,043	11
12	BUILDING IMPROVEMENT			1986	23,799		20			23,799	12
13	BUILDING IMPROVEMENT			1987	30,173		20			30,173	13
14	BUILDING IMPROVEMENT			1990	94,921		15			94,921	14
15	BUILDING IMPROVEMENT			1991	700		10			700	15
16	BUILDING IMPROVEMENT			1992	9,135	609	15	609		6,268	16
17	BUILDING IMPROVEMENT			1993	112,022	7,468	15	7,468		76,860	17
18	BUILDING IMPROVEMENT			1993	115,471	7,698	15	7,698		73,132	18
19	BUILDING IMPROVEMENT			1994			10				19
20	BUILDING IMPROVEMENT			1995	32,918	2,195	15	2,195		18,231	20
21	PHONE SYSTEM			1996	23,095	2,309	10	2,309		17,129	21
22	INSTALL FIRE HOUSE			1995	1,228	82	15	82		621	22
23	ELEVATOR IMPROVEMENTS			1996	3,356	224	15	224		1,641	23
24	RECEPTION AREA			1996	1,598	106	15	106		772	24
25	TWO SETS OF STEEL DOORS			1995	3,250	217	15	217		1,661	25
26	CABINETS IN RECEPTION AREA			1995	3,500	233	15	233		1,770	26
27	MOTOR FOR ELEVATOR			1996	2,042	136	15	136		942	27
28	TUB RESURFACING			1996	4,900	327	15	327		2,232	28
29	CONCRETE RAMP			1996	700	47	15	47		315	29
30	ROOF SHAFT & EXHAUST			1996	1,110	74	15	74		499	30
31	FLOOR DRAIN			1997	2,300	153	15	153		971	31
32	BOX ELEVATOR			1997	1,950	130	15	130		802	32
33	CONCRETE LUNCH AREA			1997	4,313	287	15	287		1,773	33
34	ROOF WORK			1997	45,658	3,044	15	3,044		18,771	34
35	BOX ON ELEVATOR			1998	525	35	15	35		207	35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number LAKEVIEW LIVING CENTER # 0028134 Report Period Beginning: 07/01/02 Ending: 06/30/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	LIGHTING	1998	$ 2,715	$ 181	15	$ 181	$	$ 1,041	37
38	PLUMBING	1998	700	47	15	47		257	38
39	SPRINKLER SYSTEM	1998	2,531	169	15	169		979	39
40	ROOF TOP EXHAUST FAN	1998	635	42	15	42		236	40
41	ELECTRIC DOOR STRIKE	1998	582	39	15	39		230	41
42	GLASS	1998	679	45	15	45		264	42
43	CARPET	1999	518	34	15	34		152	43
44	DOOR	1999	680	45	15	45		166	44
45	BATHROOM RENOVATIONS	2000	8,800	587	15	587		1,503	45
46	PLUMBING	2001	2,100	140	15	140		303	46
47	SHOWER BASE AND TILES	2001	2,200	147	15	147		293	47
48	TUCK POINTING BRICK	2001	43,284	2,886	15	2,886		5,050	48
49	STEEL DOORS	2002	1,430	95	15	95		135	49
50	RESURFACE BATHTUB	2002	1,120	75	15	75		100	50
51	WATER LINE MOTOR	2002	1,275	85	15	85		106	51
52	ELEVATOR EDGE	2001	1,696	113	15	113		217	52
53	ELEVATOR DOORS	2002	920	61	15	61		87	53
54	WATER LINE	2002	1,750	117	15	117		126	54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 2,327,463	$ 75,596		$ 75,596	$	$ 1,195,359	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number LAKEVIEW LIVING CENTER # 0028134 Report Period Beginning: 07/01/02 Ending: 06/30/03

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 326,987	$ 37,406	$ 37,406	$	5-10YRS	$ 181,171	71
72	Current Year Purchases	120,634	3,548	3,548		5-10YRS	3,548	72
73	Fully Depreciated Assets	521,584		2,929	2,929		521,584	73
74	PARENT COMPANY ALLOCATION							74
75	TOTALS	$ 969,205	$ 40,954	$ 43,883	$ 2,929		$ 706,303	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	RESIDENT TRANSPORTAT	85 DODGE VAN	2002	$ 2,800	$ 560	$ 560	$	5	$ 840	76
77	RESIDENT TRANSPORTAT	2002 FORD VAN	2002	23,986	4,798	4,798		5	5,197	77
78	RESIDENT TRANSPORTAT	2003 FORD VAN	2003	24,502	408	408		5	408	78
79										79
80	TOTALS			$ 51,288	$ 5,766	$ 5,766	$		$ 6,445	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 3,389,472	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 122,316	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 125,245	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 2,929	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,908,107	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [ ] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. N/A
This amount was calculated by dividing the total amount to be amortized N/A
by the length of the lease .

9. Option to Buy: [ ] YES [ ] NO Terms: N/A *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2004	$
13.	/2005	$
14.	/2006	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO

16. Rental Amount for movable equipment: $ 24,189 Description: COPIER $14460, DISHWASHER $2400, CORPORATE ALLOC. $7329
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number LAKEVIEW LIVING CENTER # 0028134 Report Period Beginning: 07/01/02 Ending: 06/30/03

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [X] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM	X
IN OTHER FACILITY	
COMMUNITY COLLEGE	
HOURS PER AIDE	40

3. CLINICAL PORTION:

IN-HOUSE PROGRAM	X
IN OTHER FACILITY	
HOURS PER AIDE	80

B. EXPENSES

ALLOCATION OF COSTS (d)

			1	2	3	4
			Facility			
			Drop-outs	Completed	Contract	Total
1	Community College Tuition		$	$	$	$
2	Books and Supplies			575		575
3	Classroom Wages	(a)		8,489		8,489
4	Clinical Wages	(b)		16,137		16,137
5	In-House Trainer Wages	(c)				
6	Transportation					
7	Contractual Payments					
8	Nurse Aide Competency Tests					
9	TOTALS		$	$ 25,201	$	$ 25,201
10	SUM OF line 9, col. 1 and 2	(e)	$ 25,201			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$ N/A

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	23
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	23

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number LAKEVIEW LIVING CENTER **#** 0028134 **Report Period Beginning:** 07/01/02 **Ending:** 06/30/03

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 06/30/03 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 14,819	$ 14,819	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (65,187))	1,346,302	1,346,302	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	9,893	9,893	6
7	Other Prepaid Expenses	9,239	9,239	7
8	Accounts Receivable (owners or related parties)	4,033,391	4,033,391	8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 5,413,644	$ 5,413,644	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	41,516	41,516	13
14	Buildings, at Historical Cost	1,585,984	1,585,984	14
15	Leasehold Improvements, at Historical Cost	741,479	741,479	15
16	Equipment, at Historical Cost	1,020,493	1,020,493	16
17	Accumulated Depreciation (book methods)	(1,908,107)	(1,908,107)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	535,159	535,159	21
22	Other Long-Term Assets (specify):			22
23	Other(specify): LOAN COST	174,075	174,075	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 2,190,599	$ 2,190,599	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 7,604,243	$ 7,604,243	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 665,706	$ 665,706	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	86,087	86,087	28
29	Short-Term Notes Payable	51,615	51,615	29
30	Accrued Salaries Payable	129,424	129,424	30
31	Accrued Taxes Payable (excluding real estate taxes)	10,105	10,105	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	111,053	111,053	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,053,990	$ 1,053,990	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	40,478	40,478	39
40	Mortgage Payable			40
41	Bonds Payable	2,613,000	2,613,000	41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 2,653,478	$ 2,653,478	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 3,707,468	$ 3,707,468	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 3,896,775	$ 3,896,775	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 7,604,243	$ 7,604,243	48

***(See instructions.)**

Facility Name & ID Number LAKEVIEW LIVING CENTER # 0028134 Report Period Beginning: 07/01/02 Ending: 06/30/03

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 3,885,030	1
2	Restatements (describe):		2
3	PRIOR PERIOD AUDIT ADJUSTMENT	(322,516)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 3,562,514	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	334,261	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 334,261	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 3,896,775	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number LAKEVIEW LIVING CENTER # 0028134 Report Period Beginning: 07/01/02 Ending: 06/30/03

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 5,854,812	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,854,812	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education	1,458,676	9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements	36,152	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 1,494,828	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	7,678	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 7,678	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	MISCELLANEOUS	329	28
28a	VENDING	2,975	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 3,304	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 7,360,622	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	799,850	31
32	Health Care	2,445,771	32
33	General Administration	1,528,910	33
	B. Capital Expense		
34	Ownership	426,101	34
	C. Ancillary Expense		
35	Special Cost Centers	1,476,273	35
36	Provider Participation Fee	349,456	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 7,026,361	40
41	**Income before Income Taxes (line 30 minus line 40)****	334,261	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 334,261	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? NO If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number LAKEVIEW LIVING CENTER # 0028134 Report Period Beginning: 07/01/02 Ending: 06/30/03

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,922	2,042	$ 50,935	$ 24.94	1
2	Assistant Director of Nursing	2,426	2,631	47,896	18.20	2
3	Registered Nurses					3
4	Licensed Practical Nurses	16,107	17,488	306,345	17.52	4
5	Nurse Aides & Orderlies					5
6	Nurse Aide Trainees	2,808	2,808	24,626	8.77	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants					10
11	Social Service Workers	2,088	2,300	20,872	9.07	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	22,254	24,150	206,520	8.55	15
16	Dishwashers					16
17	Maintenance Workers	6,346	6,928	76,760	11.08	17
18	Housekeepers	10,310	11,008	87,152	7.92	18
19	Laundry	4,566	5,060	48,247	9.53	19
20	Administrator	3,769	4,025	132,674	32.96	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	9,131	9,884	104,437	10.57	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	15,596	16,496	240,748	14.59	28
29	Resident Services Coordinator	3,768	4,111	73,005	17.76	29
30	Habilitation Aides (DD Homes)	159,138	171,663	1,505,816	8.77	30
31	Medical Records	1,381	1,488	11,009	7.40	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	261,610	282,082	$ 2,937,042 *	$ 10.41	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	177	$ 8,674	L1, C3	35
36	Medical Director	MONTHLY	127	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant	111	6,105	L10A, C3	40
41	Occupational Therapy Consultant	78	4,290	L10A, C3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	293	11,710	L10A, C3	43
44	Activity Consultant				44
45	Social Service Consultant	634	33,665	L12, C3	45
46	Other(specify)				46
47		MONTHLY	41,009	L10, C3	47
48					48
49	TOTAL (lines 35 - 48)	1,293	$ 105,580		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number LAKEVIEW LIVING CENTER # 0028134 Report Period Beginning: 07/01/02 Ending: 06/30/03

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
JOHN MIRECKI	ADMINISTRATOR	0	$ 61,705
EUGENE HUMPHREY	ADMINISTRATOR	0	70,969
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 132,674

B. Administrative - Other

Description	Amount
DEVELOPMENTAL SERVICES OF ILLINOIS, INC. ADMINISTRATIVE SERVICE FEES	$ 269,003
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 269,003

C. Professional Services

Vendor/Payee	Type	Amount
		$
PERSONNEL PLANNERS, INC	U/C CONSULTATION	2,595
LAWRENCE MANSON	LEGAL	8,940
BANK ONE/IL HEALTH FAC	BOND FEES	3,135
AMERICAN EXPRESS T&B	ACCOUNTING	34,879
HEINOLD-BANWART	ACCOUNTING	1,182
PARENT COMPANY	ALLOCATION	40,549
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $2500 attach copy of invoices.)		$ 91,280

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 90,498
Unemployment Compensation Insurance	52,492
FICA Taxes	224,040
Employee Health Insurance	193,714
Employee Meals	44,450
Illinois Municipal Retirement Fund (IMRF)*	
UNION PENSION FUND	30,340
FLU SHOTS	1,223
EMPLOYEE MORAL	1,225
TOTAL (agree to Schedule V, line 22, col.8)	$ 637,982

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
N/A		
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 400
Advertising: Employee Recruitment	2,728
Health Care Worker Background Check	1,015
(Indicate # of checks performed 145)	
ILLINOIS HEALTH CARE DUES	7,094
VEHICLE LICENSE	234
MISCELLANEOUS DUES & FEES	975
CITY LICENSE/PERMITS	1,673
NAEIR MEMBERSHIP	338
SAMS CLUB	110
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 14,567

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	10,364
Seminar Expense	3,580
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 13,944

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number LAKEVIEW LIVING CENTER # 0028134 Report Period Beginning: 07/01/02 Ending: 06/30/03

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number LAKEVIEW LIVING CENTER **#** 0028134 **Report Period Beginning:** 07/01/02 **Ending:** 06/30/03

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **YES**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **ILLINOIS HEALTH CARE ASSOC. $7094**

(3) Did the nursing home make political contributions or payments to a political action organization? **NO** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **7.5 YEARS**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **0** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **349,456**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **44,450** Has any meal income been offset against related costs? **NO** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **81%**
d. Have vehicle usage logs been maintained? **ADEQUATE RECORDS ARE MAINTAINED**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **YES**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **YES**
Firm Name: **HEINOLD - BANWART, LTD.** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **YES** If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees.